

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31389  
State File No. \_\_\_\_\_  
Registrar's No. 8700

BIRTH NO. _____		REG. DIST. NO. <b>318</b>	PRIMARY REG. DIST. NO. <b>1003</b>	Registrar's No. <b>8700</b>
1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b> b. COUNTY <b>Peoria</b>		
b. CITY OR TOWN <b>St. Louis, Mo.</b>		c. CITY OR TOWN <b>Peoria</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. LENGTH OF STAY (in this place) _____		e. STREET ADDRESS (If rural, give location) <b>705 Rohmann</b>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>				
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH		
a. (First) <b>Chester</b>	b. (Middle) <b>Leslie</b>	c. (Last) <b>Reid</b>	(Month) <b>October</b>	(Day) <b>4</b> (Year) <b>1955</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 7, 1892</b>	9. AGE (In years last birthday) <b>63</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Eddyville, Ill.</b>	
13a. FATHER'S NAME <b>James D. Reid</b>		13b. MOTHER'S MAIDEN NAME <b>India Holoway</b>		14. NAME OF HUSBAND OR WIFE <b>Pearl</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Pearl Bozarth Reid, Peoria, Ill.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs</b>		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES		
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <b>Arteriosclerotic heart disease</b>		
		DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. <b>diabetes</b>		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____		
22. I hereby certify that I attended the deceased from <b>Sept 17</b> , 19 <b>55</b> , to <b>October 4</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>October 4</b> , 19 <b>55</b> , and that death occurred at <b>9:20 p.m.</b> , from the causes and on the date stated above.				
23a. SIGNATURE <b>David O. McKinstry MD</b>		23b. ADDRESS <b>BARNES HOSPITAL</b>		23c. DATE SIGNED <b>10-4-55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>10-5-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Park View</b>	24d. LOCATION (City, town, or county) <b>Peoria, Ill.</b> (State) _____	
DATE REC'D BY LOCAL REG. <b>OCT 5 1955</b>	REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b> ADDRESS <b>4700 Washington Blvd.</b>		

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Elmo R. Schwel*.....

Licensed Embalmer No. *407*.....

P. O. Address *St. Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.